THE PSYCHONEUROSES *

LOUIS CASAMAJOR
Professor of Neurology, Columbia University

The treatment of the psychoneuroses comprises a good part of the modern practice of medicine. There can be no accurate estimation of the prevalence of these conditions for, if one should define them rather broadly, a very large majority of all adult, civilized humans would well come under the classification. Psychoneurotic states, of some degree, are so general that one often feels inclined to dispense with the term as descriptive of a condition and to substitute a term indicating a state of mind. Were such a term to be found we could then speak of psychoneurotic thinking rather than a psychoneurotic state.

Not all psychoneurotics come to physicians for treatment of their psychoneuroses. Many there are who maintain an adequate adjustment to reality, satisfactory, to some degree, to both the psychoneurotic needs and the needs of the life they have to live. Others maintain this balance so long as things go well with their internal physiology, but when disease attacks them they come to the doctor with a mixture of organic disease and psychoneuroses which the disease itself has served to release as a clinical state.

Such is the scope of the subject and its very extent necessitates a rigid restriction of the scope of this paper. Time permits us to consider here, and briefly, only those more striking psychoneurotic mal-adaptations which have been gathered together into clinical states and to which descriptive names have been applied.

To understand the psychoneuroses as products, in part, of civilization one must envisage the history of civilization and especially the price man has paid, in restriction of freedom of personal action, for the greater benefits that have come with civilization. Since the psychoneurosis is largely a matter of point of view, it is necessary also to

* Delivered October 18, 1929.

consider the history of medicine, especially of the development of man's point of view toward his sicknesses.

Back before the dawn of history disease was looked upon as of supernatural causation. The wrath of the Gods, punishment for sins, demoniacal possession and other mechanisms of magic were the only factors in etiology. This point of view persists in some guise to a considerable extent to-day. Hippocrates and his followers stressed the theory of organic causation in an attempt to rid medicine of magic. They have succeeded only partially and the materialists of a later day did almost as much to obstruct the proper understanding of man's illnesses as did the deists and medicine men of an earlier civilization.

The psychogenic idea was the direct descendant of magic in that it stood in opposition to the organic causation theory. In its birth with Paracelsus and later Mesmer (1734-1815) it was hardly distinguishable from magic. The early hypnotism was well mixed with astrology. Mesmer, however, held ideas about "imagination" as a cause of symptoms. With Charcot psychopathology began to take on more of the appearance of science and then evolved the concept that diseases could be either organic or functional in nature. The functional were those without demonstrable organic lesions. The term "functional" exists to-day hardly better defined than that, although it is becoming more and more to be admitted that most if not all of the diseases we call "functional" are psychogenic in origin. If those terms should eventually be proven to be synonymous the older one had best be discarded.

Following Charcot, the psychogenic theory has made mighty strides. Formulations have become more accurate with the clearer knowledge of the workings of the human mind. Most of all we owe to Charcot's most distinguished pupil, Sigmund Freud, the system of psychology which enables us best to understand those mental processes which make men feel sick.

To understand the psychoneurosis one must understand the general situation of the individual who feels sick. This

feeling of sickness, his interpretation of it and his fears about it are what urge him to seek medical aid. The essential thing is that he feels sick and the neurosis as it is presented to us is an explanation of his feeling badly. Symptoms become necessary as the need for the explanation becomes greater. If one can speak of the need for the neurosis, then the neurosis comes to be in some degree an asset. The individual must gain something by being neurotic. Admittedly he loses a great deal by the neurosis and often the asset value is difficult to determine. In the compensation neurosis and the litigation neurosis the hope of monetary recompense and the desire for revenge are easily understandable factors. In many of the others it is much less easy to appreciate, for often the asset is a purely personal one of self esteem in that the neurosis is an acceptable solution of the problem of the patient which consists of conflict between his instinctive life and a reality none too pleasant to face.

It is best not to speak of causes of the psychoneuroses for so many factors enter into the genesis of such a complex mental state that usually each can play a minor role of varying importance. One may better speak of determinants each one of which is but a partial cause. The principal determinants of the neurosis reside in the personality of the patient. Naturally this includes about everything that may have entered into the individual's development. Here we encounter his instinctive endowment—both the ego instinct and the sexual. Of importance also is his training and education, his methods of handling himself in regard to his environment, his methods of handling his instinctive trends and his opportunities for the release of instinct engendered energy.

Of all the instinctive trends those which have to do with the sexual are by far the most important in the majority of neuroses. Sexual motives and desires are not only extremely potent but also are the ones which must be most actively curbed in civilized society. Did sexuality consist only of propagation instinct and mating desires the prob-

lem would be relatively simple. But sexuality is complicated by its many side issues, partial trends, in the main, with a reality in the life history of the individual and bearing a burden of shame, not infrequently disgust, in the mind of the adult living, of necessity, in a world of customs and morals. These trends are grouped in the infantile sexuality for it is at that level that they arise and are partially organized. Among these partial trends are more or less erotic attachments to parents, brothers, sisters and others; masturbation desires and practices; anal erotism and a number of so-called perverse tendencies of major or minor importance. Their importance depends not only on the relative dynamic force of the wish behind them but the degree to which they have been assimulated into the personality and their ability to exist in the company of more adult, social and "respectable" motives.

Such as these are factors which exist in every life, and may remain, as latent personality trends under one group of living conditions but under others may become important determinants of a psychoneurosis. Over against the personality stands the life the individual has to live; and his degree of normality or neurosis depends on how satisfactorily he is able to adjust himself to his life, how near the middle line he can steer his course.

From such a survey of the psychogenic theory it becomes obvious how difficult adequate classification of the psychoneuroses is; as difficult as a classification of the human race. Nosological terms which seek to describe causes are almost always inaccurate. Such terms as "Traumatic Neurosis" applied to cases where compensation or litigation are also factors, are especially fallacious. One might as accurately call them "Compensation Neurosis." The trauma was a determinant only because it served to release the underlying more important determinants. The kind of trauma has very little to do with the neurosis. The kind of man who sustained the trauma is the all important consideration. The term "Post-Traumatic Neurosis"

while better, still leaves much to be desired. Other systems of classification based on the anatomical localization of symptoms are equally useless. They become unwieldy due to their own complexity and lose their theme in a maze of words. It must be admitted that no hard and fast classification is possible and that under any classification, borderline and mixed cases make up a considerable number of the whole; nevertheless that offered by psychoanalysis is by far the most accurate and practical. It deals with the mental states behind the symptoms and hence has the greatest etiological significance.

Freud divided the neuroses into two groups. 1, The Actual Neuroses and 2, The Psychoneuroses.

A. Actual Neuroses
   1. Anxiety Neurosis
   2. Neurasthenia

B. Psychoneuroses
   a. Hysteria
      1. Conversion Hysteria
      2. Anxiety Hysteria
   b. Compulsion Neurosis (Obsession)

According to Wechsler "The actual neuroses may be regarded as mixtures of psychogenesis and organic pathogenesis. They represent clinical entities in which regression plays a comparatively small part and the precipitating trauma the leading role. The conception is that an otherwise well adjusted individual sustains an accidental injurious experience by which the whole organism is, as it were, overwhelmed and more or less disorganized."

"The psychoneuroses on the other hand are the results of conflicts and regression to various points of infantile fixation. The neurosis represents an attempt at adjustment and one may see in it evidence of repair. The clinical manifestations therefore are colored by the restitutional efforts and represent some sort of compromise formation between regression and adjustment."

Time permits of but brief description of these clinical types. Anxiety neurosis is the form most commonly seen.

Its outstanding factor is the anxious expectation. Its symptoms include a sense of vague but intense fear, feelings of impending death and dread of serious disease or insanity, palpitation of the heart, shortness of breath, dizziness, tremblings, feelings of faintness and all of the other symptoms of fear. The cause lies in the immediate sexual life of the patient; in situations where sexual stimulation is great and organic relief negligible or nil. This is the case in the "engagement neurosis" where courtship is prolonged and violent, in women whose husbands practice coitus interruptus or who suffer from ejaculatio praecox, in individuals where abstinence is enforced but can not be endured and a host of other conditions where the same general principle applies.

Neurasthenia, as the term has been restricted by Freud, is a very rare condition. Clinically it is manifested by general lack of energy, easy mental and physical fatigability, mild gastro-intestinal disturbances, feelings of pressure in head, neck and spine, and frequently impotence and low blood pressure. The main etiological factor is the opposite of that for the anxiety neurosis: an excess of the physical response in sexual life with little or an insufficient amount of the psychic concomitant. Hence it is seen most frequently as the result of prolonged or excessive masturbation, ejaculatio praecox and similar conditions.

Clinically the psychoneuroses differ from the actual neuroses very little. In clinical observation the latter merge gradually with the former and many states that have persisted for any considerable length of time are definitely borderline conditions. Often it is a matter mainly of degree. The difference is one of mechanisms not of symptoms. Hysteria is a method of handling tendencies and symptoms in an attempt to retain adequate contact with reality and make some degree of social life possible.

Conversion hysteria is a term employed to define psychoneurotic states where the neurosis is converted into physical symptoms. The psychological state accompanying

these symptoms is of utmost importance for the diagnosis as well as for the treatment although clinically the outstanding features are the physical symptoms. The hysterical personality with its infantile reactions to life and its inability to adjust at the adult level of reality lies at the bottom. The physical symptoms of conversion hysteria are multiplex. Hysterical pains, paraesthesias and anaesthesias; hysterical paralysis, contractions and convulsions; hysterical blindness and aphonia are but a part of the symptoms.

In the anxiety hysteria the anxiety dominates the picture. Back of it all is the same hysterical personality. Hence the anxiety hysteria appears as a thing much less in touch with reality than does the anxiety neurosis. There is much more of the infantile regression. Often however only very careful analytic study can establish the differential diagnosis.

The compulsion neurosis occurs at a much deeper unconscious level than does hysteria as the latter is deeper in its localization than the actual neurosis. The prime symptom is the compulsive idea—the obsession. The obsession may consist of fears, in which case the term phobic neurosis has been used, or compulsive acts or thoughts. Freud has described it as the "tabu neurosis." The phobias and the ceremonial for handling the phobia make up the bulk of the clinical picture. One may, of course, apply terms descriptive of each individual phobia, "agarophobia," "misophobia" and the like and describe "handwashing manias," "touching manias," etc., as separate clinical types but such attempts are not only confusing but futile. The clinical picture is less important than the person. The compulsive idea which forms the core of the compulsion neurosis is very similar to an insane delusion and differs from it mainly in that with the former considerable insight is preserved. The patient recognizes the unreality of the phobia in contrast to real things of life and its absurdity, but in spite of that he must react to it

in his compulsive way in order to attain any degree of comfort.

Such then in very briefest, are the clinical pictures of the neuroses. The hopeless inadequacy of this description proves the futility of attempts to classify them this way. The psychoneuroses are not clinical states; they are states of mind. Possibly there are no such things as the psychoneuroses; only is there psychoneurotic thinking.